Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRIDE
5701 MAPLE AVENUE SUITE 100
DALLAS TX 75235

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-2249-01

MFDR Date Received
MARCH 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: In accordance with DWC rule 134.600 (c) (B) and (p) (B) (10) an insurance carrier is liable for all reasonable and necessary medical costs relating to interdisciplinary pain management, functional restoration, physical/occupational therapy and or counseling when it was pre-authorized prior to providing the care. As can be seen from the attachments the medical care in question was preauthorized at the address the care was provided. Texas Mutual Insurance Company (TMIC) and the Texas Star HCN were aware throughout the entire process (and for 2 years prior to the initial denial of benefits) that PRIDE was a non-network provider of rehabilitation services. Unique electronic billing requirement requested by Texas Star HCN were established for PRIDE services in mid-2008, and used continuously from that time forward. At the time all services were pre-authorized. Dr. Larry Johnson, a PRIDE physician independent contractor was listed as Requesting Provider. For those reasons the carrier is liable for the medical services that are subject of this request for Dispute Resolution."

Amount in Dispute: $15,523.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2010 through June 23, 2010	Chronic Pain Management Program – CPT Code 97799-CP-CA	$15,497.40	$0.00
June 23, 2010	Exercise Equipment – Code A9300	$26.00	$0.00
TOTAL		$15,523.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305 defines a medical fee dispute and non-network care.
3. Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 7, 2010 , June 8, 2010, June 11, 2010, July 12, 2010, July 13, 2010, July 26, 2010, August 4, 2010
   - CAC-38-Services not provided or authorized by designated (Network/Primary Care) Providers.
   - 727-Provider not approved to treat Texas Star Network Claimant. For Network information call 800-381-8067.

   Explanation of benefits dated September 16, 2010, September 17, 2010, September 21, 2010
   - CAC-38-Services not provided or authorized by designated (Network/Primary Care) Providers.
   - 727-Provider not approved to treat Texas Star Network Claimant. For Network information call 800-381-8067.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824.

   Explanation of benefits dated June 21, 2010
   - CAC-W1-Workers Compensation state fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

   Explanation of benefits dated August 11, 2010
   - CAC-38-Services not provided or authorized by designated (Network/Primary Care) Providers.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 727-Provider not approved to treat Texas Star Network Claimant. For Network information call 800-381-8067.

   Explanation of benefits dated September 16, 2010
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-38-Services not provided or authorized by designated (Network/Primary Care) Providers.
   - 727-Provider not approved to treat Texas Star Network Claimant. For Network information call 800-381-8067.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.

Issues

Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?

Findings

28 Texas Administrative Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care ***not*** [emphasis added] delivered, or arranged by a certified workers" compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.305, and §133.307, the

Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/28/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.